THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-4937.M4

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address T.E.A.M.S. 2646 S. Loop West #290 Houston, TX 77050	MDR Tracking No.: M4-04-2859-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Lumbermen's Underwriting Alliance 12200 Ford Road, Ste. 344 Dallas, TX 75234 BOX 19	Date of Injury: Employer's Name: Transport Labor Contract Leasing Insurance Carrier's No.: TX 279979

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10/24/02	10/24/02	99499-L1-WP	$900.00	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary not submitted. The Requestor's rationale on the Table of Disputed Services states, "We received no response from the IC. WE believe this is according to the TWCC guidelines and feel payment should be submitted".

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary states in part, "…This is a fee dispute concerning date of service 10/24/02. Provider has used the modifier L1, which corresponds to a date beyond two years from date of injury. Evaluation/Management Ground Rules XXIV.C.3. This is clearly incorrect as the date of injury was ___ and the date of service is 6 months later…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 99499-L1-WP for date of service 10/24/02. EOBs were not submitted by either party. Per Rule 133.307(e)(2)(B) the requestor has submitted convincing evidence of request for reconsideration. Per the 1996 Medical Fee Guideline, Evaluation/Management Ground Rule (XXIV)(C)(3)(a) the requestor has used an incorrect modifier. Modifier L1 is used for first RME if beyond two years from date of injury; therefore, reimbursement is not recommended

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Ordered by:

	Marguerite Foster	02/17/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____